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State-Specific Mortality from Stroke and Distribution of Place of Death — United States, 1999

In the United States, stroke is the third leading cause of death and one of the major causes of serious, long-term disability among adults. Each year, approximately 500,000 persons suffer a first-time stroke, and approximately 167,000 deaths are stroke-related (*1*). This report presents national and state-specific death rates for stroke in 1999, which indicate state-by-state variations in both stroke-related death rates and the proportions of stroke decedents who die before transport to an emergency department (ED). Prevention through public and medical education remains a key strategy for reducing stroke-related deaths and disability.

CDC compiled national and state mortality data based on death certificates from state vital statistics offices (*2*). Demographic data were reported by funeral directors or provided by family members of the decedent. Stroke-related deaths are those for which the underlying cause listed on the death certificate by a physician or a coroner is classified according to the *International Classification of Diseases, Tenth Revision* (ICD-10) codes I60–I69. Stroke subtypes are defined as subarachnoid hemorrhagic stroke (I60), intracerebral hemorrhagic stroke (I61–I62), ischemic stroke (I63–I67), and sequelae of stroke (I69). Place of death was defined as either pretransport, dead on arrival (DOA), in the ED, or in the hospital after admission. Pretransport deaths occurred at the decedent's residence, in a nursing home, or in an extended-care facility before transport to a hospital or ED. Stroke-related death rates for groups defined by age, sex, race/ethnicity, stroke subtype, and state were determined by dividing the number of deaths by the population at risk in that group. Estimates of resident populations and age-adjusted death rates were calculated by using the 2000 U.S. standard population (*3*).

Among U.S. residents, 167,366 stroke-related deaths occurred in 1999, with an age-adjusted rate of 63.4 per 100,000 population. The greatest proportion of deaths occurred among persons aged ≥85 years (40.1%) followed by those aged 75–84 years (34.3%), those aged 65–74 years (14.4%), and those aged <65 years (11.2%). Age-specific death rates increased for successive age groups (Table 1). By race/ethnicity, the highest age-adjusted death rates for stroke occurred among blacks followed by whites (225.2 and 166.7 per 100,000 population, respectively). Age-adjusted death rates for stroke were slightly higher among men (62.4) than among women (60.5). Ischemic strokes accounted for 68.3% of all stroke-related deaths; age-adjusted death rates were higher for ischemic stroke than for all other stroke subtypes.

In 1999, a total of 79,663 (47.6%) stroke-related deaths occurred pretransport, 926 (0.7%) occurred as DOA, 5,519 (3.3%) occurred in the ED, and 80,369 (48.0%) occurred after admission to the hospital; for 889 (0.5%) deaths, place-of-death data were not available. The proportion of pretransport deaths increased with age, and the proportion of deaths that occurred as DOA or in the ED decreased with age. The proportion of pretransport deaths was higher among women (52.2%) than among men (40.3%) and higher among whites (50.1%) than among other racial/ethnic populations.

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Conversely, the proportion of stroke-related deaths that occurred in the ED was higher among blacks (5.8%) than among other racial/ethnic populations, and higher among Hispanics (4.8%) than among non-Hispanics (3.2%). Compared with other stroke subtypes, the highest proportion of pretransport deaths was among persons who died of sequelae of stroke or other cerebrovascular disease (69.1%), followed by ischemic stroke (23.3%), subarachnoid hemorrhagic stroke (13.7%), and intracerebral hemorrhagic stroke (12.6%). Persons who died of subarachnoid hemorrhagic stroke accounted for the highest proportion of deaths that occurred as DOA or in the ED (1.1% and 7.8%, respectively).

The state-specific, age-adjusted death rates for stroke ranged from 33.0 per 100,000 population in New Hampshire to 83.8 in South Carolina (Table 2). The proportion of pretransport deaths ranged from 23.3% in the District of Columbia to 67.3% in Oregon. States with ≥60% of stroke deaths reported as occurring pretransport were Colorado (60.0%), Wisconsin (60.7%), Utah (60.7%), Minnesota (62.1%), Idaho (64.0%), Washington (64.4%), Vermont (67.2%), and Oregon (67.3%). The proportion of stroke-related deaths reported as DOA ranged from zero to 4.6%; those having occurred in the ED ranged from 0.8% to 8.3%. The proportion of stroke-related deaths for which place-of-death data were missing ranged from zero to 11.2%.

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Editorial Note: The findings in this report indicate that ischemic strokes account for most stroke-related deaths and that state-by-state variations exist in the proportion of stroke-related deaths that occur pretransport. These findings are consistent with other evidence that many acute ischemic stroke patients cannot benefit from thrombolytic therapy because they do not reach medical treatment in time (*4–6*). Thrombolytic therapy is a time-dependent therapy with a window of efficacy of ≤3 hours after the onset of symptoms (*4*). The reported prehospital delay ranges from 1 to 14 hours, with 3–6 hours as the typical time range (*6*). Because the advent of thrombolytic therapy has made the early recognition of stroke symptoms and rapid medical response imperative, educational programs are needed for both health-care providers and the public to reduce stroke-related deaths and disability.

Educating the public about signs and symptoms of stroke, the need for emergency response (i.e., calling 911), and the importance of immediate transport to an ED might help promote prompt and effective treatment. State-by-state variations in the proportion of stroke-related deaths that occurred

TABLE 1. Number, rate*, and place of stroke-related deaths†, by selected characteristics — United States, 1999

Characteristic	No.	Rate	Place of death				
			Pretransport	DOA§	ED¶	In hospital	Data missing
Age group (yrs)							
0–34	976	(0.7)	11.6%	1.1%	10.7%	75.5%	1.1%
35–44	2,574	(5.7)	14.7%	1.9%	9.4%	73.5%	0.5%
45–54	5,563	(15.5)	15.7%	1.0%	6.9%	75.7%	0.7%
55–64	9,652	(41.3)	19.5%	0.7%	5.5%	73.6%	0.6%
65–74	24,092	(132.2)	30.2%	0.5%	4.3%	64.2%	0.7%
75–84	57,427	(472.8)	45.8%	0.5%	3.2%	50.0%	0.5%
≥85	67,080	(1,606.7)	63.9%	0.5%	2.1%	33.2%	0.4%
Race/ethnicity							
White	144,827	(166.7)	50.1%	0.5%	2.9%	46.0%	0.5%
Black	18,884	(225.2)	32.2%	1.1%	5.8%	59.9%	0.9%
American Indian/Alaska Native	546	(99.6)	35.7%	0.7%	3.5%	59.9%	0.2%
Asian/Pacific Islander	3,109	(123.9)	28.6%	0.4%	4.1%	66.2%	0.8%
Hispanic	5,907	(100.6)	30.8%	0.3%	4.8%	63.6%	0.4%
Non-Hispanic**	161,459	(179.4)	48.2%	0.6%	3.2%	47.4%	0.5%
Sex							
Male	64,485	(62.4)	40.3%	0.6%	3.7%	54.9%	0.5%
Female	102,881	(60.5)	52.2%	0.5%	3.0%	43.7%	0.5%
Stroke subtype††							
Subarachnoid hemorrhage	6,489	(2.4)	13.7%	1.1%	7.8%	76.8%	0.6%
Intracerebral hemorrhage	25,461	(9.4)	12.6%	0.3%	5.4%	80.7%	0.9%
Ischemic	114,253	(42.2)	23.3%	0.6%	2.7%	42.9%	0.5%
Sequelae of stroke	21,163	(7.8)	69.1%	0.6%	2.7%	27.3%	0.3%

* Age-adjusted death rates (per 100,000 population) were calculated by using the 2000 U.S. standard population.
† *International Classification of Disease, Tenth Revision* (ICD-10) codes I60–I69.
§ Dead on or before arrival at a hospital.
¶ Emergency department.
** Non-Hispanic includes 402 stroke deaths for which Hispanic origin was not stated.
†† Stroke subtypes were categorized as subarachnoid hemorrhagic (ICD-10 code I60), intracerebral hemorrhagic (I61–I62), ischemic (I63–I67), and sequelae of stroke (I69).

pretransport might reflect differences in public awareness of stroke symptoms. Results from population-based surveys suggest that many persons are unaware of the five most common signs and symptoms of stroke: sudden numbness or weakness, sudden dimness or loss of vision, sudden dizziness or loss of balance, sudden severe headache, and confusion or difficulty speaking. Only 57% of survey respondents in the Greater Cincinnati area and 39% in Georgia could identify at least one of these symptoms (*7,8*).

The accurate identification and rapid transport of stroke patients by emergency medical system (EMS) personnel are crucial to the successful early treatment of stroke (*9*). To assess whether a patient is having a stroke, EMS personnel should be trained properly and equipped with the appropriate technology. In addition, triage nurses and physicians in the ED should be educated to treat stroke as a medical emergency.

State-by-state variations in the proportions of stroke-related deaths by place of death might reflect different EMS policies about the need to transport persons who have already died. The high proportion (63.9%) of stroke-related deaths that occurred pretransport among adults aged ≥85 years might be explained, at least in part, by do-not-resuscitate orders in nursing homes and long-term care facilities, especially for older persons disabled by the sequelae of previous strokes. However, approximately 25% of stroke-related deaths among persons aged <65 years occurred pretransport, as DOA, or in the ED, suggesting that persons in this age group might dismiss stroke as a problem of the elderly and therefore delay their response to symptoms.

The findings in this report are subject to at least two limitations. First, data are subject to misclassification of race/ethnicity both in the population census and on death certificates, which might result in overreporting of deaths among blacks and whites and underreporting deaths among other racial/ethnic groups (*10*). Second, data on underlying cause and place of death are subject to error because they originate from the physicians or coroners who certify each death.

Because high blood pressure, diabetes, high cholesterol, and smoking remain the major risk factors for stroke, prevention through public and medical education and through risk-factor reduction should continue to be the focus of public health efforts to reduce the number of stroke-related deaths. Prevention efforts also must include broad-based public health efforts to increase awareness of stroke symptoms and

TABLE 2. Number, rate*, and place of stroke-related deaths†, by state§ — United States, 1999

State	No.	Rate	Place of death				
			Pretransport	DOA¶	ED**	In hospital	Data missing
Alabama	3,066	70.5	39.9%	0.1%	3.7%	55.6%	0.6%
Alaska	170	70.7	37.1%	0.0%	3.5%	59.4%	0.0%
Arizona	2,649	57.0	59.7%	0.1%	2.1%	38.0%	0.1%
Arkansas	2,183	77.3	42.2%	0.2%	3.4%	54.2%	0.0%
California	17,964	63.3	49.2%	0.0%	3.1%	47.3%	0.3%
Colorado	1,867	57.7	60.0%	0.0%	3.0%	36.8%	0.0%
Connecticut	1,961	50.8	54.7%	0.4%	3.5%	40.3%	1.1%
Delaware	359	49.6	44.3%	0.0%	3.1%	52.6%	0.0%
District of Columbia	339	59.9	23.3%	0.6%	8.3%	67.8%	0.0%
Florida	10,636	51.9	45.0%	0.1%	3.2%	51.6%	0.0%
Georgia	4,453	74.3	35.5%	4.6%	4.5%	54.2%	0.0%
Hawaii	760	63.0	33.0%	1.6%	5.5%	59.5%	0.4%
Idaho	764	66.5	64.0%	0.4%	2.6%	32.9%	0.1%
Illinois	7,487	62.0	45.4%	2.2%	4.0%	48.4%	0.0%
Indiana	4,128	70.6	52.3%	0.1%	3.2%	44.3%	0.0%
Iowa	2,300	62.2	52.8%	0.1%	2.1%	45.0%	0.0%
Kansas	1,785	59.7	50.5%	0.1%	2.0%	47.5%	0.0%
Kentucky	2,645	69.3	43.5%	0.4%	2.9%	52.6%	0.0%
Louisiana	2,705	70.2	28.9%	0.8%	3.1%	64.2%	0.0%
Maine	873	62.9	58.5%	0.1%	2.1%	39.3%	0.0%
Maryland	2,879	62.9	53.9%	0.6%	4.0%	41.5%	0.0%
Massachusetts	3,563	50.5	54.6%	0.2%	2.0%	42.7%	0.4%
Michigan	5,951	62.3	50.6%	0.3%	3.7%	45.3%	0.1%
Minnesota	2,972	59.5	62.1%	0.1%	1.6%	35.5%	0.8%
Mississippi	1,769	67.6	30.4%	0.7%	6.0%	62.9%	0.0%
Missouri	4,106	68.7	48.4%	0.1%	2.5%	48.7%	0.2%
Montana	599	62.7	57.4%	0.0%	2.0%	40.6%	0.0%
Nebraska	1,187	61.2	56.2%	0.0%	2.9%	40.9%	0.0%
Nevada	928	63.5	32.5%	0.0%	3.8%	63.4%	0.3%
New Hampshire	690	33.0	54.5%	0.3%	2.6%	42.5%	0.1%
New Jersey	4,073	46.9	37.2%	0.2%	3.2%	59.4%	0.1%
New Mexico	789	52.8	51.8%	0.2%	3.4%	44.5%	0.0%
New York	7,954	41.2	35.7%	0.4%	3.4%	59.8%	0.6%
North Carolina	5,649	78.4	45.3%	0.4%	3.3%	50.6%	0.4%
North Dakota	554	69.2	51.1%	0.0%	1.8%	47.1%	0.0%
Ohio	7,199	61.8	54.4%	0.5%	3.4%	40.6%	1.1%
Oklahoma	2,401	67.6	43.5%	0.3%	3.3%	52.8%	0.0%
Oregon	2,803	78.7	67.3%	0.0%	2.1%	30.6%	0.0%
Pennsylvania	8,655	58.5	50.7%	0.4%	2.9%	46.0%	0.0%
Rhode Island	648	51.1	58.6%	0.6%	1.7%	33.5%	5.6%
South Carolina	2,910	83.8	44.3%	0.4%	4.6%	50.6%	0.0%
South Dakota	569	63.4	54.3%	0.2%	0.9%	44.6%	0.0%
Tennessee	4,395	83.3	37.0%	3.4%	4.7%	54.1%	0.7%
Texas	10,552	67.1	41.7%	0.3%	4.2%	53.6%	0.2%
Utah	881	61.0	60.7%	0.3%	2.7%	36.2%	0.0%
Vermont	335	56.0	67.2%	0.6%	1.5%	30.7%	0.0%
Virginia	4,108	69.8	44.0%	0.5%	2.7%	40.6%	11.2%
Washington	3,724	69.9	64.4%	0.0%	0.8%	34.7%	0.0%
West Virginia	1,333	63.6	39.2%	0.9%	3.1%	56.7%	0.0%
Wisconsin	3,841	67.3	60.7%	0.1%	1.9%	37.2%	0.0%
Wyoming	255	59.5	55.1%	0.0%	2.4%	42.5%	0.0%
Total	**167,366**	**63.4**	**47.6%**	**0.5 %**	**3.3%**	**48.0%**	**0.5%**

* Age-adjusted death rates (per 100,000 population) were calculated by using the 2000 U.S. standard population.
† *International Classification of Disease, Tenth Revision* (ICD-10) codes I60–I69.
§ Percentages for place of death are based on state of occurrence.
¶ Dead on or before arrival at a hospital.
** Emergency department.

to foster an appropriate and timely response from health-care providers and the public.

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Fetal Alcohol Syndrome — Alaska, Arizona, Colorado, and New York, 1995–1997

Fetal alcohol syndrome (FAS) is caused by maternal alcohol use during pregnancy and is one of the leading causes of preventable birth defects and developmental disabilities in the United States (*1*). FAS is diagnosed on the basis of a combination of growth deficiency (pre- or postnatal), central nervous system (CNS) dysfunction, facial dysmorphology, and maternal alcohol use during pregnancy. Estimates of the prevalence of FAS vary from 0.2 to 1.0 per 1,000 live-born infants (*2–4*). This variation is due, in part, to the small size of the populations studied, varying case definitions, and different surveillance methods. In addition, differences have been noted among racial/ethnic populations (*5*). To monitor the occurrence of FAS, CDC collaborated with five states (Alaska, Arizona, Colorado, New York, and Wisconsin*) to develop the Fetal Alcohol Syndrome Surveillance Network (FASSNet). This report summarizes the results of an analysis of FASSNet data on children born during 1995–1997, which indicate that FAS rates in Alaska, Arizona, Colorado, and New York ranged from 0.3 to 1.5 per 1,000 live-born infants and were highest for black and American Indian/Alaska Native populations. This study demonstrates that FASSNet is a useful tool that enables health care professionals to monitor the occurrence of FAS and to evaluate the impact of prevention, education, and intervention efforts.

FASSNet is a standardized, multiple-source FAS surveillance method supported by CDC through cooperative agreements with four state health departments and one university. Surveillance is conducted statewide in Arizona and Alaska and in selected areas of Colorado (Denver-Boulder Consolidated Metropolitan Statistical Area) and New York (nine counties in western New York). FASSNet participants use the same general surveillance methodology, including a common case definition for confirmed and probable FAS (Table 1); multiple sources to identify cases (e.g., hospitals, birth defects monitoring programs, genetic clinics, developmental clinics, early intervention programs, and Medicaid files); a common electronic data abstraction form; and quality assurance procedures to maintain consistency among sites (*6*). The surveillance case definition is based on criteria from the 1996 Institute of Medicine report on FAS (*1*), which were adapted for use by FASSNet by a committee of experts in dysmorphology, psychology, and public health surveillance. Each state used multiple sources to identify potential cases, including *International Classification of Diseases, Ninth Revision* (ICD-9) code 760.71 (newborn affected by alcohol via placenta or breast milk) in hospital discharge data sets or birth defects monitoring programs, specialty clinic records of prenatal alcohol exposure or suspected FAS, and health-care provider referral of children to a state FASSNet program. Case status was determined electronically through application of computer algorithms (derived from the surveillance case definition) by evaluating the combined data from all abstracted records for each child.

The analysis included only children who were born during 1995–1997 to a mother then residing in a surveillance area and who, based on medical record information abstracted during June 1998–March 2002, met the surveillance case definition for confirmed or probable FAS (Table 1). The denominator for the prevalence calculations consisted of all births to women residing in the selected surveillance area as determined by birth certificate data. For reporting purposes, the mother's race/ethnicity on the birth certificate was used to classify the child's race/ethnicity.

* Because Wisconsin uses a different surveillance methodology, its data are not included in this report.

TABLE 1. Fetal Alcohol Syndrome Surveillance Network case definition categories

Case definition category	Phenotype positive		
	Face	Central Nervous System (CNS)	Growth
Confirmed Fetal Alcohol Syndrome (FAS) phenotype with or without maternal alcohol exposure*	Abnormal facial features consistent with FAS as reported by a physician or Two of the following: • short palpebral fissures • abnormal philtrum • thin upper lip	Frontal-occipital circumference ≤10th percentile at birth or any age or Standardized measure of intellectual function ≤1 standard deviation below the mean or Standardized measure of developmental delay ≤1 standard deviation below the mean or Developmental delay or mental retardation diagnosed by a qualified examiner (e.g., psychologist or physician) or Attention deficit disorder diagnosed by a qualified evaluator	Intrauterine weight or height corrected for gestational age ≤10th percentile or Postnatal weight or height ≤10th percentile for age or Postnatal weight for height ≤10th percentile
Probable FAS phenotype with or without maternal alcohol exposure*	Required; facial features same as above	Must meet either CNS or growth criteria as outlined above	

* Documentation in the records of some level of maternal alcohol use during the index pregnancy.

Records for 1,489 children were reviewed and abstracted; information was abstracted from more than one record source (including birth certificates) for 1,338 (90%) children who might have FAS. A total of 209 children (14%) met the surveillance case definition for confirmed or probable FAS; 24 (11%) were excluded from the analysis because they were born outside the surveillance area. Of the remaining 185 children with confirmed or probable FAS, 142 (77%) met the confirmed definition, and 43 (23%) met the probable definition. Children with a probable diagnosis were included because they were likely to have FAS given that they met FAS-specific dysmorphic facial criteria and at least one other criterion (e.g., CNS abnormalities or growth retardation). Although health-care provider documentation of maternal alcohol use during pregnancy is not required to meet the confirmed or probable case definition, such documentation existed in at least one abstracted record for 170 (92%) of the 185 children.

The overall 3-year prevalence of FAS varied only slightly in three of the four sites, from 0.3 to 0.4 per 1,000 live-born infants; the prevalence in Alaska was 1.5 (Table 2), due primarily to a high rate among American Indians/Alaska Natives. The highest prevalence rates observed during the surveillance period were among blacks in two states (range: 0.9–1.6) and among American Indians/Alaska Natives in two states (range: 2.5–5.6).

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Editorial Note: This report demonstrates that maternal alcohol use during pregnancy continues to affect children. Recent data indicate that the prevalence of binge (i.e., >5 drinks on any one occasion) and frequent drinking (i.e., >7 drinks per week or >5 drinks on any one occasion) during pregnancy reached a high point in 1995 and has not declined (*7*).

FASSNet prevalence rates are similar to rates published previously from population-based prevalence studies, despite different case definitions and surveillance methods (*2*). These data indicate that children born to mothers in certain racial/ethnic populations have consistently higher prevalence rates of FAS. For example, FAS prevalence was 3.0 per 1,000 live-born infants for American Indians/Alaska Natives during 1977–1992 compared with 0.2 for other Alaska residents during the same period (*4*). FASSNet findings confirm higher prevalence rates among black and American Indian/Alaska Native populations. Alaska health authorities have increased

TABLE 2. Number and prevalence rate* of fetal alcohol syndrome cases, by race/ethnicity — Alaska, Arizona, Colorado†, and New York§, Fetal Alcohol Syndrome Surveillance Network, 1995–1997

	Alaska			Arizona			Colorado			New York			Total		
Race/ethnicity¶	No. births	No. cases	Rate	No. births	No. cases	Rate	No. births	No. cases	Rate	No. births	No. cases	Rate	No. births	No. cases	Rate
White, non-Hispanic	19,007	5	0.3	114,851	15	0.1	63,653	11	0.2	68,932	18	0.3	**266,443**	**49**	**0.2**
Black	1,341	0	—	7,054	4	**	5,508	5	0.9	13,455	21	1.6	**27,358**	**30**	**1.1**
Hispanic	1,287	0	—	80,626	16	0.2	21,579	8	0.4	3,635	0	—	**107,127**	**24**	**0.2**
Asian/Pacific Islander	1,493	0	—	4,371	1	**	2,556	0	—	1,693	0	—	**10,113**	**1**	**
AI/AN††	7,117	40	5.6	15,685	39	2.5	1,744	1	**	627	1	**	**25,173**	**81**	**3.2**
Other/unknown§§	39	0	—	456	0	—	96	0	—	447	0	—	**1,038**	**0**	**—**
Total	**30,284**	**45**	**1.5**	**223,043**	**75**	**0.3**	**95,136**	**25**	**0.3**	**88,789**	**40**	**0.4**	**437,252**	**185**	**0.4**

* Per 1,000 population.
† Denver-Boulder Consolidated Metropolitan Statistical Area.
§ Nine counties in western New York.
¶ Black includes black Hispanic and non-Hispanic; Hispanic excludes black Hispanic.
** Rates were not calculated when the number of cases was <5.
†† American Indian/Alaska Native.
§§ Other non-Hispanic and unknown.

efforts to address this health problem. Increased awareness of maternal alcohol use and more complete documentation by Alaska Native health organizations might result in more vigilant reporting of potential cases of FAS, which could contribute to high reported FAS prevalence in this population (*4*).

The number of children affected adversely by in-utero exposure to alcohol is probably underestimated for at least four reasons. First, some FAS cases might not be diagnosed because of the syndromic nature of the condition, the lack of pathognomonic features, and the negative perceptions of FAS diagnosis. Second, medical records of children with FAS often lack sufficient documentation to determine case status. For example, 10 children diagnosed with FAS by a clinical geneticist, dysmorphologist, or developmental pediatrician did not meet the surveillance case definition for confirmed or probable FAS because documentation in the abstracted medical records was insufficient or the child did not meet FASSNet surveillance case definition criteria. However, adding these 10 children to the total case count would change the overall prevalence only slightly, from 0.43 to 0.45 per 1,000 live-born infants. Third, some children might not be identified as having FAS until they reach school age, at which point CNS abnormalities and learning disabilities are recognized more easily. Because only part of the cohort under surveillance was of school age and education records were not used in this surveillance system, the actual number of cases might have been underestimated. Finally, an unknown number of persons with FAS left the surveillance area before being identified by the surveillance system. Because of the small numbers and differences in sources and awareness among clinicians, prevalence rates across racial/ethnic populations and across states should be compared with caution.

Ongoing, consistent, population-based surveillance systems are necessary to measure the occurrence of FAS and the impact of FAS prevention activities. These systems also are useful in evaluating the need for early intervention and special education services for children with birth defects such as FAS. One of the national health objectives for 2010 is to reduce the occurrence of FAS (objective no. 16-18) (*8*); however, no national surveillance program exists to evaluate progress in achieving this objective. FASSNet data can be used in conjunction with maternal alcohol exposure surveillance system data to monitor trends and identify high-risk populations for targeted prevention efforts.

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Nonfatal Self-Inflicted Injuries Treated in Hospital Emergency Departments — United States, 2000

CDC, in collaboration with the Consumer Product Safety Commission (CPSC), expanded CPSC's National Electronic Injury Surveillance System (NEISS) in July 2000 to include all types and external causes of nonfatal injuries treated in U.S. hospital emergency departments (EDs) (*1*). This ongoing surveillance system, called NEISS All Injury Program (NEISS-AIP), provides data to calculate national estimates for nonfatal injuries treated in EDs during 2000. This report provides national, annualized, weighted estimates of nonfatal self-inflicted injuries treated in U.S. hospital EDs. Overall, self-inflicted injury rates were highest among adolescents and young adults, particularly females. Most (90%) self-inflicted injuries were the result of poisoning or being cut/pierced with a sharp instrument, and 60% were probable suicide attempts. NEISS-AIP data increase understanding of self-inflicted injuries and can serve as a basis for monitoring trends, facilitating additional research, and evaluating intervention approaches.

NEISS-AIP includes data from 66 of the 100 NEISS hospitals, which were selected as a stratified probability sample of all hospitals in the United States and its territories with a minimum of six beds and a 24-hour ED (*2,3*). The NEISS-AIP hospitals are a nationally representative sample of U.S. hospital EDs. NEISS-AIP provides data on approximately 500,000 injury- and consumer product–related ED cases each year. Data from these cases are weighted by the inverse of the probability of selection to provide national estimates (*2*). Annualized estimates for this report are based on weighted data for 2,008 nonfatal self-inflicted injuries treated in EDs during July–December 2000. The weight of each case was doubled, and then these weighted values were added to provide annualized estimates for the overall population and population subgroups (i.e., age, sex, and race/ethnicity*). A direct variance estimation procedure was used to calculate 95% confidence intervals and to account for the complex sample design (*2*).

Injuries were defined as bodily harm resulting from acute exposure to an external force or substance, including unintentional and violence-related causes. Cases were excluded if 1) the principal diagnosis was an illness, pain only, psychological harm (e.g., anxiety and depression) only, contact dermatitis associated with exposure to consumer products (e.g., body lotions, detergents, and diapers) and plants (e.g., poison ivy), or unknown; or 2) the ED visit was for adverse effects of therapeutic drugs or of surgical and medical care (*4*). Injuries were classified into mutually exclusive categories according to the intent of injury (i.e., unintentional, assault, self-inflicted, and legal intervention†). This analysis is limited to nonfatal self-inflicted injuries. Data about sex, race/ethnicity, injury mechanism (e.g., fall, struck by/against, and cutting/piercing), and disposition were collected. The mechanism of injury represents the precipitating mechanism that initiated the chain of events leading to the injury, similar to the underlying cause for injury-related death. Mechanisms of injury were classified into recommended major external cause-of-injury groupings (*4,5*) by using definitions consistent with *International Classification of Diseases, Ninth Revision, Clinical Modifications* (ICD-9-CM) external-cause coding guidelines (*6*). To evaluate the likelihood that a nonfatal self-inflicted injury was suicide-related, CDC analyzed verbatim text comments recorded in the NEISS-AIP database from ED patient charts for each injury. A self-inflicted injury was categorized as a probable suicide attempt if the text comments specifically indicated that the injury resulted from an attempt to take one's own life. A self-inflicted injury was deemed a possible attempt if the chart did not explicitly mention suicidal behavior but indicated that the patient had a history of condition(s) associated with suicidal behavior (e.g., depression or a previous suicide attempt). The remaining self-inflicted injuries were categorized as unclear/unknown regarding intent.

During 2000, an estimated 264,108 persons were treated in EDs for nonfatal self-inflicted injuries (rate: 95.9 per 100,000 population) (Table 1); the rate for females (107.7) was higher than that for males (83.6). An estimated 170,222 (65%) injuries resulted from poisonings, 65,256 (25%) were attributed to injuries with a sharp instrument, and 3,016 (1%) involved a firearm (Table 1). The causes of self-inflicted injuries were similar for males and females, although the proportion attributed to poisoning was higher for females (72%) than for males (55%). An estimated 129,832 (49%) persons were treated and released from EDs, 85,287 (32%) required hospitalization, and 41,784 (16%) were transferred to another institution for care. An estimated 158,466 self-inflicted injuries (60%) were considered probable suicide attempts, and 27,294 (10%) were considered possible attempts; for 78,358 self-inflicted injuries (30%), the information in the text field was unclear/unknown regarding intent. By age, rates were highest among adolescents aged 15–19 years and young adults aged 20–24 years (259.0 and 236.6, respectively), with the highest rate occurring among females aged 15–19 years (322.7). By race/ethnicity, rates were highest among white, non-Hispanic males (71.8) and females (93.9).

* Often only one entry is available on the ED record for race/ethnicity. The classification scheme for this report assumed that most white Hispanics probably were recorded on ED record as Hispanics and that most black Hispanics probably were recorded as black.

† Injuries inflicted by law enforcement personnel during official duties.

TABLE 1. Estimated number*, percentage†, and rate§ of nonfatal self-inflicted injuries treated in hospital emergency departments, by selected characteristics — United States, 2000

Characteristic	Male				Female				Total			
	No.	(%)	Rate	(95% CI¶)	No.	(%)	Rate	(95% CI)	No.	(%)	Rate	(95% CI)
Age group (yrs)												
0– 9	262**	(0.2)**	—**	—**	196**	(0.1)**	—**	—**	458**	(0.2)**	—**	—**
10–14	3,860	(3.4)	37.9	(14.8– 61.0)	10,066	(6.6)	103.6	(67.6–139.7)	13,926	(5.3)	70.0	(44.5– 95.4)
15–19	20,326	(18.1)	198.7	(125.7–271.8)	31,200	(20.6)	322.7	(225.1–420.3)	51,526	(19.5)	259.0	(180.4–337.5)
20–24	20,044	(17.8)	212.5	(132.4–292.6)	23,761	(15.7)	261.5	(138.9–384.2)	43,805	(16.6)	236.6	(141.8–331.4)
25–34	26,967	(24.0)	145.4	(86.6–204.1)	33,654	(22.2)	178.2	(112.7–243.8)	60,630	(23.0)	161.9	(102.2–221.7)
35–44	25,215	(22.4)	113.1	(69.8–156.5)	33,276	(21.9)	147.2	(88.4–206.0)	58,492	(22.1)	130.3	(83.6–177.0)
45–54	11,939	(10.6)	65.7	(39.4– 92.0)	12,867	(8.5)	67.7	(42.2– 93.3)	24,806	(9.4)	66.7	(43.3– 90.2)
≥55	3,828	(3.4)	14.8	(8.1– 21.5)	6,637	(4.4)	20.2	(11.0– 29.3)	10,465	(4.0)	17.8	(10.9– 24.7)
Race/ethnicity††												
White, non-Hispanic	69,156	(61.5)	71.8	(40.0–103.6)	94,259	(62.2)	93.9	(53.2–134.6)	163,414	(61.9)	83.1	(47.8–118.4)
Black	10,128	(9.0)	60.4	(33.1– 87.6)	12,575	(8.3)	67.8	(38.2– 97.4)	22,703	(8.6)	64.3	(37.2– 91.3)
Hispanic	8,339**	(7.4)**	—**	—**	9,483**	(6.3)**	—**	—**	17,822**	(6.7)**	—**	—**
Other, non-Hispanic	2,802**	(2.5)**	—**	—**	3,409**	(2.2)**	—**	—**	6,211**	(2.4)**	—**	—**
Unknown	22,025**	(19.6)**	—**	—**	31,932**	(21.1)**	—**	—**	53,957**	(20.4)**	—**	—**
Cause												
Cut/pierce	32,670	(29.1)	24.3	(15.2– 33.3)	32,586	(21.5)	23.2	(13.9– 32.4)	65,256	(24.7)	23.7	(15.4– 32.1)
Poisoning	61,503	(54.7)	45.7	(31.2– 60.2)	108,739	(71.7)	77.3	(52.0–102.5)	170,222	(64.5)	61.8	(42.4– 81.3)
Firearm	2,658**	(2.4)**	—**	—**	358**	(0.2)**	—**	—**	3,016**	(1.1)**	—**	—**
Other	14,905	(13.3)	11.1	(6.6– 15.5)	8,991	(5.9)	6.4	(3.2– 9.6)	23,896	(9.0)	8.7	(5.2– 12.2)
Unknown	714**	(0.6)**	—**	—**	984**	(0.6)**	—**	—**	1,698**	(0.6)**	—**	—**
Disposition												
Treated/released	54,322	(48.3)	40.4	(28.8– 52.0)	75,510	(49.8)	53.6	(33.8– 73.5)	129,832	(49.2)	47.2	(32.2– 62.1)
Transferred	8,008	(16.0)	13.4	(6.2– 20.5)	23,776	(15.7)	16.9	(8.1– 25.7)	41,784	(15.8)	15.2	(7.3– 23.0)
Hospitalized	36,214	(32.2)	26.9	(14.2– 39.6)	49,073	(32.4)	34.9	(20.2– 49.5)	85,287	(32.3)	31.0	(17.5– 44.4)
Other	3,219**	(2.9)**	—**	—**	2,943**	(1.9)**	—**	—**	6,161**	(2.3)**	—**	—**
Unknown	686**	(0.6)**	—**	—**	357**	(0.2)**	—**	—**	1,044**	(0.4)**	—**	—**
Injury category												
Probable suicide	65,395	(58.2)	48.6	(31.1– 66.1)	93,061	(61.4)	66.1	(42.7– 89.5)	158,466	(60.0)	57.6	(37.4– 77.8)
Possible suicide	12,873	(11.4)	9.6	(4.9– 14.2)	14,422	(9.5)	10.2	(5.1– 15.4)	27,294	(10.3)	9.9	(5.2– 14.6)
Unclear/unknown	34,182	(30.4)	25.4	(17.7– 33.1)	44,176	(29.1)	31.4	(19.8– 42.9)	78,358	(29.7)	28.5	(19.9– 37.0)
Total	**112,450**	**(100.0)**	**83.6**	**(57.0–110.1)**	**151,658**	**(100.0)**	**107.7**	**(71.8–143.7)**	**264,108**	**(100.0)**	**95.9**	**(65.4–126.5)**

* Includes weighted data for persons of unknown sex.
† Some percentages do not total 100% because of rounding.
§ Per 100,000 population.
¶ Confidence interval.
** National estimate might be unstable because it is based on <20 cases or the coefficient of variation is >30%.
†† Black includes Hispanic and non-Hispanic; Hispanic excludes black Hispanic. Rates should be interpreted with caution because of high percentage of unknowns.

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Editorial Note: The findings in this report highlight the magnitude of nonfatal self-inflicted injuries in the United States and their disproportionate impact on females and young persons. This report supplements previous NEISS-AIP summary results by providing descriptive characteristics of self-inflicted injuries.

A substantial proportion of persons who deliberately harmed themselves might not have intended to die. Further study is required to clarify the relation between self-inflicted injuries and suicidal behavior and to identify the unique characteristics of self-inflicted injuries that are not intended to result in death. Defining the differences or similarities between the various categories of self-inflicted injuries (i.e., those that are suicide-related and those that are not) might have important implications for prevention efforts of these injuries.

The findings in this report are subject to at least three limitations. First, estimates are based on data collected for a 6-month period and might not reflect seasonal differences in the number of self-inflicted injuries. Second, outcomes are specific to ED visits and do not include more distant outcomes (e.g., those resulting from hospitalization or transfer to another facility). Finally, the number of probable suicide attempts might be underestimated. NEISS-AIP data are based only on information contained in ED records and are not linked or supplemented with other data sources (e.g., hospital discharge records or police records). A patient might be unable or unwilling to report a self-inflicted injury initially as suicidal behavior but might do so later, or a health-care provider might not ask specific questions about intent.

The estimate of probable suicides in this report is lower than that in the National Hospital Ambulatory Medical Care Survey (NHAMCS) (*7*). NEISS-AIP records only the initial ED visit; NHAMCS records both the initial ED visit and any subsequent visits related to a specific injury event.

Methods to identify external cause for violent injury (*8*) and to standardize nomenclature (*9*) need to be improved.

This analysis highlights the usefulness of NEISS-AIP for estimating the number of self-inflicted injuries treated in U.S. hospital EDs and for providing descriptive information about those injuries. NEISS-AIP data can help public health professionals understand better the magnitude and characteristics of self-inflicted injuries and serve as a basis for monitoring trends, facilitating additional research on the costs and consequences of injuries, and evaluating suicide prevention efforts such as the National Strategy for Suicide Prevention (*10*).

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Notice to Readers

National High Blood Pressure Education Month, May 2002

May is National High Blood Pressure Education Month in the United States. Approximately 50 million persons in the United States aged ≥6 years have high blood pressure (i.e., a person with systolic blood pressure of ≥140 mm Hg or a diastolic blood pressure of ≥90 mm Hg or a person taking antihypertensive medication) (*1*). High blood pressure increases the risk for diseases of the heart and stroke, the first and third leading causes of death in the United States, respectively.

Lowering high blood pressure will reduce new events and deaths from these cardiovascular diseases and can be achieved through lifestyle modifications alone or in combination with drug therapy (*2*). Key lifestyle changes include weight reduction and control, adequate physical activity, moderation in alcohol intake, reduced dietary sodium, and increased dietary potassium. Additional lifestyle changes to improve overall cardiovascular health include smoking cessation and reduced intake of saturated fats. The most recent recommendations for the detection and treatment of high blood pressure are available from the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (*2*).

During May, many CDC-sponsored state cardiovascular health programs, the National High Blood Pressure Education Program, and the American Heart Association will highlight activities that raise awareness and understanding about high blood pressure as a risk factor for heart disease and stroke. Additional information about how high blood pressure can be prevented or treated is available from the American Heart Association at http://www.americanheart.org, the National Heart, Lung, and Blood Institute at http://www.nhlbi.nih.gov/about/nhbpep, and CDC at http://www.cdc.gov/nccdphp/cvd.

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Notice to Readers

World No-Tobacco Day, May 31, 2002

"Tobacco-Free Sports—Play It Clean" is the theme designated by the World Health Organization (WHO) for this year's World No-Tobacco Day, May 31, 2002. This year's theme is intended to raise awareness about the dangers of tobacco use, to heighten concern about the marketing and advertising of tobacco products through sports, and to promote participation in sports and physical activity as a healthy alternative to tobacco use. By 2030, tobacco use will cause an estimated 10 million deaths each year worldwide (*1*). Because sports have a universal appeal, WHO and CDC are collaborating to encourage tobacco-free policies and health promotion activities at sporting events worldwide.

In 1986, the Federation Internationale de Football Association (FIFA) stopped accepting tobacco advertising or sponsorship for the FIFA World Cup. The International Olympic Committee's (IOC) tobacco-free Olympics tradition began at the 1988 Winter Olympic Games in Calgary. Since then, all Olympic Games have been smoke-free (*2*). In February 2002, CDC and WHO, in collaboration with the IOC, evaluated the smoke-free policies of both the IOC and the 2002 Salt Lake City Organizing Committee for the Olympic Winter Games. An on-site assessment by CDC found high levels of awareness of, and compliance with, the Olympic policies among athletes, journalists, and spectators. Approximately 75% of those who responded to the assessment survey thought the IOC should require all of the bidding cities for the Olympic Games to implement a tobacco-free policy (CDC, unpublished data, 2002).

The 2002 FIFA World Cup begins May 31 in Seoul. To ensure that athletes and visitors at this event have a smoke-free environment, WHO and CDC worked with FIFA on a tobacco-free policy. The tobacco-free sports theme also will be highlighted at the American College of Sports Medicine's annual meeting in St. Louis, which will be held in conjunction with IOC's Sports Science Congress, May 28–June 1, 2002.

Additional information about World No-Tobacco Day 2002 is available from WHO at http://tobacco.who.int and from CDC at http://www.cdc.gov/tobacco, telephone 800-232-1311.

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Notice to Readers

National Stroke Awareness Month, May 2002

May is National Stroke Awareness Month in the United States. Stroke is the third leading cause of death in the United States and is a leading cause of serious, long-term disability. During 2002, approximately 500,000 persons in the United States will have a first-time stroke, and an additional 100,000 will have a recurrent attack (*1*).

New developments in treatment of ischemic stroke have shown that thrombolytic medications might make the difference between disability and full recovery (*2*), but thrombolytic treatment is effective only if given within 3 hours of onset of symptoms. Among persons who died of stroke in 1999, 48% of deaths occurred before transport to a hospital or emergency department. Recognizing stroke symptoms and seeking prompt emergency assistance can help reduce stroke death and disability.

During May, several CDC-sponsored Cardiovascular Health State Programs, the National Stroke Association, the American Stroke Association, and other federal agencies will highlight programs and activities about prevention and awareness of stroke and its risk factors. For example, the Cardiovascular Health State Program in several states will be collaborating with the American Stroke Association to implement "Operation Stroke," an initiative to increase public awareness of stroke symptoms and the need to call 911 and to improve emergency and medical care for stroke.

Additional information about stroke, warning signs, risk factors, prevention, treatment, and new research is available from CDC at http://www.cdc.gov/nccdphp/cvd, from the Centers for Medicare and Medicaid Services at http://www.hcfa.gov/quality/11.htm, from the National Institute of Neurological Disorders and Stroke at http://www.ninds.nih.gov, from the American Heart Association/American Stroke Association at http://www.americanheart.org and http://www.strokeassociation.org, from the Brain Attack Coalition at http://www.stroke-site.org, and from the National Stroke Association at http://www.stroke.org.

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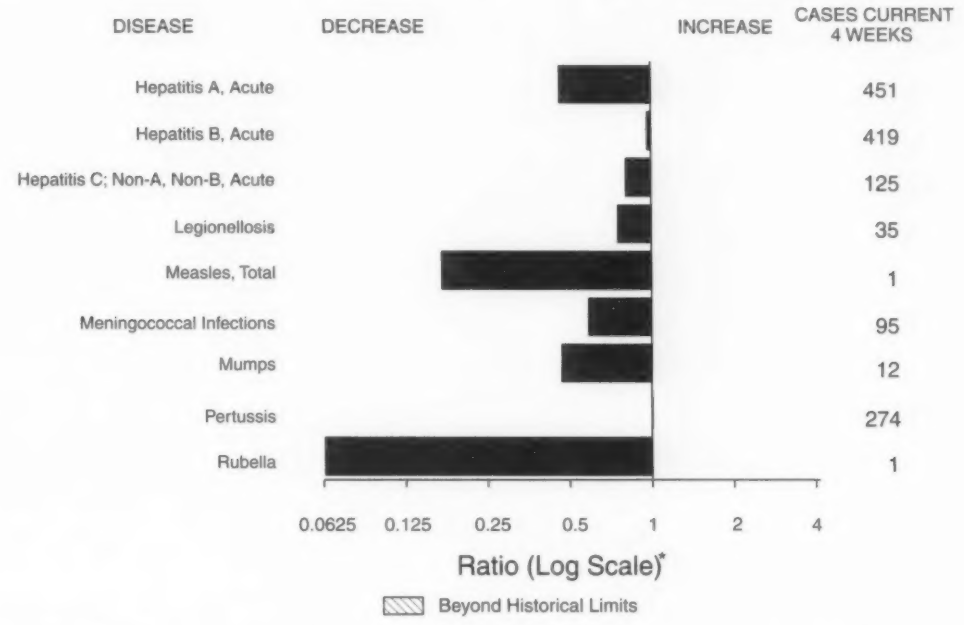
FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending May 18, 2002, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending May 18, 2002 (20th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		1	-	Encephalitis: West Nile†	1	-
Botulism:	foodborne	6	9	Hansen disease (leprosy)†	28	37
	infant	17	43	Hantavirus pulmonary syndrome†	2	3
	other (wound & unspecified)	7	4	Hemolytic uremic syndrome, postdiarrheal†	40	33
Brucellosis†		27	23	HIV infection, pediatric†§	31	64
Chancroid		25	15	Plague	-	-
Cholera		1	2	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		43	46	Psittacosis†	10	4
Diphtheria		-	1	Q fever†	10	4
Ehrlichiosis:	human granulocytic (HGE)†	36	27	Rabies, human	-	1
	human monocytic (HME)†	17	14	Streptococcal toxic-shock syndrome†	30	42
	other and unspecified	2	1	Tetanus	4	14
Encephalitis:	California serogroup viral†	6	-	Toxic-shock syndrome	46	54
	eastern equine†	-	-	Trichinosis	5	5
	Powassan†	-	-	Tularemia†	11	16
	St. Louis†	-	-	Yellow fever	1	-
	western equine†	1	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update April 28, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	13,092	13,255	269,086	289,380	721	691	500	500	19	28
NEW ENGLAND	459	460	9,676	8,770	32	30	36	47	2	14
Maine	8	14	524	507	1	3	1	6	-	-
N.H.	13	13	616	486	9	-	3	6	-	2
Vt.	5	10	279	224	7	9	1	2	-	-
Mass.	243	266	3,833	3,577	6	12	21	21	2	4
R.I.	42	38	1,010	1,045	5	3	3	4	-	-
Conn.	148	119	3,414	2,931	4	3	7	8	-	8
MID. ATLANTIC	2,520	3,711	27,377	29,590	81	102	36	44	-	-
Upstate N.Y.	304	584	5,965	4,888	26	27	27	25	-	-
N.Y. City	1,397	2,043	11,452	11,297	35	47	-	3	-	-
N.J.	544	602	1,517	4,093	6	4	9	16	-	-
Pa.	275	482	8,443	9,312	14	24	N	N	-	-
E.N. CENTRAL	1,335	919	41,736	54,583	170	239	140	125	-	1
Ohio	269	158	7,921	14,369	51	45	23	30	-	1
Ind.	155	84	5,888	6,149	19	21	9	20	-	-
Ill.	560	436	11,122	16,173	18	18	50	29	-	-
Mich.	282	191	12,199	11,598	39	49	28	18	-	-
Wis.	69	50	4,606	6,294	43	106	30	28	-	-
W.N. CENTRAL	197	249	12,856	14,834	78	29	72	56	3	2
Minn.	45	48	3,558	3,190	29	-	27	23	3	-
Iowa	41	24	629	1,656	6	15	16	7	-	-
Mo.	66	113	4,482	5,209	12	8	15	9	-	-
N. Dak.	-	1	410	409	5	-	-	-	-	-
S. Dak.	2	-	854	713	5	3	1	4	-	1
Nebr.	22	25	574	1,328	15	3	8	4	-	1
Kans.	21	38	2,349	2,329	6	-	5	9	-	-
S. ATLANTIC	4,422	3,674	52,722	55,636	140	123	55	50	9	9
Del.	82	72	1,053	1,138	1	1	1	-	-	-
Md.	645	436	5,400	5,548	5	23	-	3	-	-
D.C.	202	293	1,273	1,396	3	7	-	-	-	-
Va.	281	309	6,283	6,738	1	7	10	12	-	1
W. Va.	25	26	896	901	1	-	1	1	-	-
N.C.	357	166	7,836	8,839	17	14	9	20	-	-
S.C.	335	237	5,259	6,497	2	1	-	2	-	-
Ga.	788	389	10,554	11,319	72	47	26	5	5	6
Fla.	1,707	1,746	14,168	13,260	38	23	8	7	4	2
E.S. CENTRAL	621	654	20,093	19,174	51	15	21	21	-	-
Ky.	109	121	3,344	3,370	1	1	4	4	-	-
Tenn.	270	197	6,427	5,731	26	2	12	10	-	-
Ala.	118	174	6,439	5,263	20	5	2	5	-	-
Miss.	124	162	3,883	4,810	4	7	3	2	-	-
W.S. CENTRAL	1,494	1,266	39,887	40,788	8	11	4	40	-	-
Ark.	100	81	1,791	3,016	4	2	1	1	-	-
La.	375	319	7,109	6,617	1	-	-	2	-	-
Okla.	77	67	4,025	3,867	3	2	3	8	-	-
Tex.	942	799	26,962	27,288	-	7	-	29	-	-
MOUNTAIN	449	510	16,672	16,597	49	44	49	45	3	-
Mont.	6	11	684	892	3	3	8	3	-	-
Idaho	8	7	871	671	15	5	5	5	-	-
Wyo.	2	1	339	316	5	1	2	1	1	-
Colo.	96	121	4,203	4,585	10	15	13	19	1	-
N. Mex.	28	42	2,600	2,403	6	8	3	3	1	-
Ariz.	191	189	4,400	5,406	5	1	5	7	-	-
Utah	22	47	1,895	299	2	9	7	4	-	-
Nev.	96	92	1,680	2,025	3	2	6	3	-	-
PACIFIC	1,595	1,812	48,067	49,408	112	98	87	72	2	2
Wash.	176	198	8,258	5,268	24	U	11	14	-	-
Oreg.	155	69	2,533	2,690	14	11	29	11	2	2
Calif.	1,242	1,520	34,686	38,878	73	86	36	41	-	-
Alaska	2	9	1,343	1,056	-	-	4	1	-	-
Hawaii	20	16	1,247	1,516	1	1	7	5	-	-
Guam	2	8	-	114	-	-	N	N	-	-
P.R.	376	406	1,382	1,156	-	-	-	-	-	-
V.I.	55	2	30	71	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	85	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update April 28, 2002.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive: All Ages, All Serotypes		*Haemophilus influenzae*, Invasive: Age <5 Years, Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	4	4	4,967	114,054	129,891	638	666	6	11
NEW ENGLAND	-	1	515	2,896	2,384	48	23	-	1
Maine	-	-	62	28	57	1	1	-	-
N.H.	-	-	18	50	51	4	-	-	-
Vt.	-	1	43	40	32	3	1	-	-
Mass.	-	-	241	1,235	1,080	22	18	-	1
R.I.	-	-	40	366	272	8	-	-	-
Conn.	-	-	111	1,177	892	10	3	-	-
MID. ATLANTIC	-	-	999	12,770	13,684	121	97	1	1
Upstate N.Y.	-	-	390	3,116	2,882	56	24	1	-
N.Y. City	-	-	436	4,696	4,692	27	26	-	-
N.J.	-	-	-	1,614	1,612	27	39	-	-
Pa.	-	-	173	3,344	4,498	11	8	-	1
E.N. CENTRAL	2	2	926	19,720	27,504	78	108	1	1
Ohio	2	2	304	4,327	7,522	45	32	-	1
Ind.	-	-	-	2,609	2,560	19	19	-	-
Ill.	-	-	217	6,012	8,635	-	42	-	-
Mich.	-	-	294	5,237	6,598	8	5	1	-
Wis.	-	-	113	1,535	2,189	6	10	-	-
W.N. CENTRAL	-	-	623	5,321	6,053	22	24	-	1
Minn.	-	-	228	1,069	986	15	11	-	-
Iowa	-	-	91	170	431	1	-	-	-
Mo.	-	-	177	2,881	3,052	4	11	-	-
N. Dak.	-	-	6	23	13	-	-	-	-
S. Dak.	-	-	21	94	88	-	-	-	-
Nebr.	-	-	49	135	468	-	1	-	1
Kans.	-	-	51	949	1,015	2	1	-	-
S. ATLANTIC	-	-	902	30,671	33,672	171	185	-	1
Del.	-	-	17	632	613	-	-	-	-
Md.	-	-	35	2,923	3,201	39	43	-	-
D.C.	-	-	16	1,080	1,162	-	-	-	-
Va.	-	-	70	4,068	3,310	10	12	-	-
W. Va.	-	-	10	358	210	2	4	-	1
N.C.	-	-	-	5,543	6,653	16	22	-	-
S.C.	-	-	20	3,053	5,012	6	4	-	-
Ga.	-	-	338	5,605	6,081	58	49	-	-
Fla.	-	-	396	7,409	7,430	40	51	-	-
E.S. CENTRAL	-	1	115	11,375	12,256	23	41	1	-
Ky.	-	1	-	1,312	1,300	2	1	-	-
Tenn.	-	-	51	3,555	3,768	14	17	-	-
Ala.	-	-	64	4,097	4,186	5	21	1	-
Miss.	-	-	-	2,411	3,002	2	2	-	-
W.S. CENTRAL	-	-	49	17,527	19,585	25	26	-	1
Ark.	-	-	49	1,032	1,925	1	-	-	-
La.	-	-	-	4,390	4,512	2	4	-	-
Okla.	-	-	-	1,772	1,787	22	21	-	-
Tex.	-	-	-	10,333	11,361	-	1	-	1
MOUNTAIN	2	-	472	3,576	3,938	91	85	2	2
Mont.	-	-	29	39	45	-	-	-	-
Idaho	-	-	25	36	32	1	1	-	-
Wyo.	-	-	8	24	21	1	-	-	-
Colo.	2	-	156	1,321	1,199	16	23	-	-
N. Mex.	-	-	60	493	380	14	12	-	-
Ariz.	-	-	62	1,022	1,504	46	39	1	1
Utah	-	-	82	149	27	9	3	-	-
Nev.	-	-	50	492	730	4	7	1	1
PACIFIC	-	-	364	10,198	10,815	59	77	1	3
Wash.	-	-	150	1,770	1,148	2	1	1	-
Oreg.	-	-	146	314	464	31	22	-	-
Calif.	-	-	-	7,739	8,821	9	36	-	3
Alaska	-	-	32	217	132	1	2	-	-
Hawaii	-	-	36	158	250	16	16	-	-
Guam	-	-	-	-	18	-	-	-	-
P.R.	-	-	-	227	272	-	-	-	-
V.I.	-	-	-	17	11	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	6	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive				Hepatitis (Viral, Acute), By Type					
	Age <5 Years									
	Non-Serotype B		Unknown Serotype		A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	111	119	7	11	3,309	3,980	2,337	2,725	1,027	2,042
NEW ENGLAND	5	6	-	-	145	181	74	53	14	22
Maine	-	-	-	-	6	5	3	4	-	-
N.H.	-	-	-	-	8	4	7	7	-	-
Vt.	-	-	-	-	-	3	2	3	7	5
Mass.	3	5	-	-	68	64	39	10	7	17
R.I.	-	-	-	-	18	8	10	8	-	-
Conn.	2	1	-	-	45	97	13	21	-	-
MID. ATLANTIC	17	14	1	-	415	558	542	578	458	1,021
Upstate N.Y.	7	2	-	-	77	94	52	47	22	12
N.Y. City	5	4	-	-	185	165	317	242	-	-
N.J.	4	4	-	-	41	223	93	171	428	982
Pa.	1	4	1	-	112	76	80	118	8	27
E.N. CENTRAL	11	20	-	1	430	437	329	271	47	90
Ohio	5	4	-	-	143	97	41	50	5	5
Ind.	5	4	-	1	22	34	9	12	-	1
Ill.	-	8	-	-	126	133	31	22	7	6
Mich.	-	-	-	-	99	139	248	185	35	78
Wis.	1	4	-	-	40	34	-	2	-	-
W.N. CENTRAL	2	1	2	2	139	180	87	107	286	517
Minn.	2	1	1	-	22	12	2	9	-	-
Iowa	-	-	-	-	32	16	10	6	1	-
Mo.	-	-	1	2	29	28	52	53	278	507
N. Dak.	-	-	-	-	1	-	1	-	-	-
S. Dak.	-	-	-	-	3	1	-	1	-	-
Nebr.	-	-	-	-	5	21	14	8	6	1
Kans.	-	-	-	-	47	102	8	30	1	9
S. ATLANTIC	27	32	-	4	1,057	731	609	513	61	33
Del.	-	-	-	-	8	3	5	7	3	1
Md.	1	4	-	-	122	87	53	52	9	3
D.C.	-	-	-	-	36	18	7	3	-	-
Va.	2	4	-	-	35	55	80	55	1	-
W. Va.	-	-	-	-	10	2	12	12	1	5
N.C.	3	1	-	4	111	46	79	83	10	7
S.C.	2	1	-	-	33	23	34	6	3	3
Ga.	13	13	-	-	250	299	194	150	10	-
Fla.	6	9	-	-	452	198	145	145	24	14
E.S. CENTRAL	7	7	-	1	65	135	62	153	70	103
Ky.	-	-	-	-	23	24	14	20	2	4
Tenn.	5	3	-	-	-	56	-	56	16	27
Ala.	2	3	-	1	20	46	26	39	2	2
Miss.	-	1	-	-	22	9	22	38	50	70
W.S. CENTRAL	6	4	-	-	44	715	162	332	7	175
Ark.	-	-	-	-	19	25	48	41	1	4
La.	1	-	-	-	11	45	9	52	6	88
Okla.	5	4	-	-	13	66	1	35	-	2
Tex.	-	-	-	-	1	579	104	204	-	81
MOUNTAIN	22	9	3	1	243	280	162	203	29	27
Mont.	-	-	-	-	7	4	3	1	-	-
Idaho	-	-	-	-	18	27	3	7	-	1
Wyo.	-	-	-	-	3	2	10	-	5	4
Colo.	2	-	-	-	40	30	39	48	16	5
N. Mex.	4	5	-	1	8	10	17	57	-	10
Ariz.	11	4	2	-	119	146	56	62	1	4
Utah	4	-	-	-	23	26	14	11	-	-
Nev.	1	-	1	-	25	35	20	17	7	3
PACIFIC	14	26	1	2	771	763	310	515	55	54
Wash.	1	-	-	1	64	33	26	40	10	12
Oreg.	4	5	-	-	38	51	56	63	9	9
Calif.	6	20	1	1	662	660	223	399	36	33
Alaska	1	-	-	-	7	12	3	3	-	-
Hawaii	2	1	-	-	-	7	2	10	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	31	52	22	86	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	24	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	230	307	132	183	1,653	1,833	369	447	8†	72§
NEW ENGLAND	8	10	15	17	61	368	22	32	-	5
Maine	1	-	2	-	-	-	1	3	-	-
N.H.	1	2	2	-	19	2	5	2	-	-
Vt.	-	4	-	-	1	1	1	-	-	1
Mass.	4	2	8	10	34	128	8	14	-	3
R.I.	-	-	1	-	7	-	1	1	-	-
Conn.	2	2	2	7	-	237	6	12	-	1
MID. ATLANTIC	55	72	22	37	1,319	1,064	82	123	4	8
Upstate N.Y.	16	17	10	9	919	255	14	16	-	4
N.Y. City	10	5	5	8	55	27	51	63	4	1
N.J.	10	9	3	13	89	260	11	30	-	1
Pa.	19	41	4	7	256	522	6	14	-	2
E.N. CENTRAL	63	77	19	26	14	102	43	61	-	10
Ohio	31	34	9	4	12	5	10	9	-	3
Ind.	4	3	1	2	2	2	1	9	-	4
Ill.	-	10	-	8	-	10	9	21	-	3
Mich.	22	16	7	10	-	-	19	15	-	-
Wis.	6	14	2	2	U	85	4	7	-	-
W.N. CENTRAL	17	22	4	3	28	56	31	16	-	6
Minn.	2	1	-	-	15	20	11	6	-	2
Iowa	4	4	1	-	5	4	2	1	-	-
Mo.	6	8	1	1	6	7	7	4	-	2
N. Dak.	-	-	1	-	-	-	1	-	-	-
S. Dak.	1	-	-	-	-	-	-	-	-	-
Nebr.	4	3	-	1	-	-	5	2	-	-
Kans.	-	6	1	1	2	25	5	3	-	2
S. ATLANTIC	47	41	19	23	171	162	113	97	1	4
Del.	3	-	-	-	21	17	1	1	-	-
Md.	4	7	3	2	92	101	27	34	-	3
D.C.	-	2	-	-	6	7	5	4	-	-
Va.	3	6	1	4	7	27	9	20	-	-
W. Va.	N	N	-	2	-	1	1	1	-	-
N.C.	4	4	2	-	22	5	7	1	-	-
S.C.	4	1	3	2	2	1	3	4	-	-
Ga.	7	4	4	6	-	-	40	15	-	1
Fla.	22	17	5	7	21	3	20	17	1	-
E.S. CENTRAL	6	26	8	8	10	5	5	11	-	2
Ky.	4	6	2	2	4	3	1	2	-	2
Tenn.	-	9	3	3	2	2	1	5	-	-
Ala.	2	7	3	3	4	-	2	3	-	-
Miss.	-	4	-	-	-	-	1	1	-	-
W.S. CENTRAL	2	8	3	16	2	43	3	6	-	1
Ark.	-	-	-	1	-	-	1	2	-	-
La.	-	5	-	-	1	2	2	2	-	-
Okla.	2	1	3	-	-	-	-	1	-	-
Tex.	-	2	-	15	1	41	-	1	-	1
MOUNTAIN	17	19	11	16	8	2	13	20	-	1
Mont.	1	-	-	-	-	-	-	2	-	-
Idaho	-	-	-	-	1	1	-	2	-	1
Wyo.	3	1	-	1	-	-	-	-	-	-
Colo.	4	8	2	3	2	-	6	10	-	-
N. Mex.	1	1	-	3	1	-	-	1	-	-
Ariz.	3	5	7	3	1	-	2	1	-	-
Utah	5	2	2	1	2	-	2	2	-	-
Nev.	-	2	-	5	1	1	3	2	-	-
PACIFIC	15	32	31	37	40	31	57	81	3	35
Wash.	1	6	3	2	-	1	5	2	-	15
Oreg.	N	N	2	4	1	4	2	6	-	2
Calif.	14	21	26	31	39	26	47	66	3	13
Alaska	-	1	-	-	-	-	1	1	-	-
Hawaii	-	4	-	-	N	N	2	6	-	5
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	N	N	-	3	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

† Of eight cases reported, three were indigenous and five were imported from another country.

§ Of 72 cases reported, 37 were indigenous and 35 were imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	699	1,273	106	98	1,968	1,957	1,854	2,404
NEW ENGLAND	52	59	5	-	239	194	296	230
Maine	4	1	-	-	3	-	19	30
N.H.	5	6	3	-	3	16	10	6
Vt.	4	4	-	-	40	22	52	33
Mass.	27	35	2	-	187	147	98	72
R.I.	4	2	-	-	1	1	19	25
Conn.	8	11	-	-	5	8	98	64
MID. ATLANTIC	67	116	11	7	112	148	327	152
Upstate N.Y.	23	36	2	2	76	82	206	-
N.Y. City	9	21	1	4	5	23	8	5
N.J.	11	23	1	-	3	2	49	61
Pa.	24	36	7	1	28	41	64	86
E.N. CENTRAL	91	169	12	13	254	222	16	16
Ohio	44	48	3	1	156	121	3	1
Ind.	18	15	-	1	16	18	4	1
Ill.	-	39	4	10	41	25	4	2
Mich.	19	40	5	1	28	20	5	8
Wis.	10	27	-	-	13	38	-	4
W.N. CENTRAL	71	81	10	10	210	88	147	129
Minn.	17	10	2	1	70	17	7	15
Iowa	10	18	-	-	69	10	18	23
Mo.	28	27	3	-	43	36	14	13
N. Dak.	-	3	1	-	-	-	8	17
S. Dak.	2	4	-	-	5	3	20	19
Nebr.	9	6	-	1	4	2	-	1
Kans.	5	13	4	8	19	20	80	41
S. ATLANTIC	124	203	16	16	154	91	794	901
Del.	5	-	-	-	2	-	9	12
Md.	3	25	3	4	17	13	119	184
D.C.	-	-	-	-	1	1	-	-
Va.	18	21	2	2	69	10	199	161
W. Va.	-	4	-	-	3	1	65	53
N.C.	14	44	1	-	14	30	238	235
S.C.	13	19	2	1	24	18	29	48
Ga.	18	30	4	7	11	8	132	128
Fla.	53	60	4	2	13	10	3	80
E.S. CENTRAL	36	79	8	3	49	36	65	126
Ky.	6	13	4	1	12	11	9	9
Tenn.	15	29	2	-	30	15	43	106
Ala.	10	29	1	-	7	7	13	11
Miss.	5	8	1	2	-	3	-	-
W.S. CENTRAL	35	243	8	8	381	109	39	598
Ark.	14	10	-	-	174	7	-	-
La.	11	52	1	2	2	2	-	3
Okla.	9	18	-	-	22	3	39	36
Tex.	1	163	7	6	183	97	-	559
MOUNTAIN	54	58	6	5	310	779	75	99
Mont.	2	-	-	-	2	6	4	14
Idaho	3	6	1	-	34	156	-	-
Wyo.	-	2	-	1	5	-	6	18
Colo.	16	23	1	1	140	141	-	-
N. Mex.	1	7	-	2	34	39	4	2
Ariz.	17	10	-	-	73	415	60	65
Utah	4	6	3	-	15	16	-	-
Nev.	11	4	1	1	7	6	1	-
PACIFIC	169	265	30	36	259	290	95	153
Wash.	33	36	-	-	126	39	-	-
Oreg.	24	33	N	N	34	14	-	-
Calif.	108	187	24	20	94	226	71	117
Alaska	1	1	-	1	2	-	24	36
Hawaii	3	8	6	15	3	11	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	1	2	-	-	-	2	34	46
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	124	62	3	12	2	-	9,277	10,403
NEW ENGLAND	-	-	-	-	-	-	551	771
Maine	-	-	-	-	-	-	54	85
N.H.	-	-	-	-	-	-	31	47
Vt.	-	-	-	-	-	-	22	31
Mass.	-	-	-	-	-	-	307	437
R.I.	-	-	-	-	-	-	25	33
Conn.	-	-	-	-	-	-	112	138
MID. ATLANTIC	8	1	-	3	-	-	1,131	1,681
Upstate N.Y.	2	-	-	1	-	-	378	295
N.Y. City	-	-	-	2	-	-	440	380
N.J.	-	-	-	-	-	-	90	608
Pa.	6	1	-	-	-	-	223	398
E.N. CENTRAL	3	5	-	2	-	-	1,534	1,432
Ohio	3	-	-	-	-	-	450	444
Ind.	-	-	-	-	-	-	120	124
Ill.	-	5	-	2	-	-	487	382
Mich.	-	-	-	-	-	-	308	239
Wis.	-	-	-	-	-	-	169	243
W.N. CENTRAL	16	18	-	5	-	-	752	583
Minn.	-	-	-	-	-	-	165	189
Iowa	-	1	-	1	-	-	122	86
Mo.	16	11	-	-	-	-	293	137
N. Dak.	-	-	-	-	-	-	9	1
S. Dak.	-	-	-	-	-	-	27	38
Nebr.	-	-	-	-	-	-	49	48
Kans.	-	6	-	4	-	-	87	84
S. ATLANTIC	83	22	1	1	-	-	2,342	2,231
Del.	-	-	-	-	-	-	15	23
Md.	11	3	1	-	-	-	215	219
D.C.	-	-	-	-	-	-	26	24
Va.	1	-	-	-	-	-	241	360
W. Va.	-	-	-	-	-	-	28	28
N.C.	50	11	-	-	-	-	318	369
S.C.	11	4	-	-	-	-	142	258
Ga.	9	1	-	-	-	-	556	348
Fla.	1	3	-	1	-	-	801	602
E.S. CENTRAL	10	10	-	-	1	-	532	529
Ky.	-	-	-	-	-	-	97	99
Tenn.	8	8	-	-	1	-	161	134
Ala.	2	1	-	-	-	-	171	172
Miss.	-	1	-	-	-	-	103	124
W.S. CENTRAL	3	3	1	-	-	-	297	1,097
Ark.	-	1	-	-	-	-	139	107
La.	-	1	-	-	-	-	61	223
Okla.	3	1	-	-	-	-	95	59
Tex.	-	-	1	-	-	-	2	708
MOUNTAIN	1	3	-	-	-	-	669	623
Mont.	-	-	-	-	-	-	31	25
Idaho	-	1	-	-	-	-	49	28
Wyo.	-	1	-	-	-	-	18	25
Colo.	-	-	-	-	-	-	182	186
N. Mex.	-	-	-	-	-	-	98	79
Ariz.	-	-	-	-	-	-	167	165
Utah	-	1	-	-	-	-	58	68
Nev.	1	-	-	-	-	-	66	47
PACIFIC	-	-	1	1	1	-	1,469	1,456
Wash.	-	-	-	-	-	-	121	142
Oreg.	-	-	-	-	-	-	129	91
Calif.	-	-	1	-	-	-	1,132	1,088
Alaska	-	-	-	-	-	-	22	16
Hawaii	-	-	-	1	1	-	65	119
Guam	-	-	-	-	-	-	-	3
P.R.	-	-	-	-	-	-	50	283
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	14	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	4,625	4,950	1,833	1,972	1,189	1,439	88	174
NEW ENGLAND	89	87	91	117	4	71	4	59
Maine	3	3	14	7	-	-	-	-
N.H.	4	1	22	6	-	-	-	-
Vt.	-	2	8	7	3	6	1	-
Mass.	61	59	40	35	-	-	3	34
R.I.	4	6	7	4	1	-	-	1
Conn.	17	16	-	58	-	65	-	24
MID. ATLANTIC	254	598	316	336	62	82	36	51
Upstate N.Y.	60	154	157	126	58	80	36	51
N.Y. City	144	149	72	92	U	U	-	-
N.J.	20	193	66	95	-	-	-	-
Pa.	30	102	21	23	4	2	-	-
E.N. CENTRAL	510	706	269	430	89	102	24	60
Ohio	291	200	109	112	-	-	1	-
Ind.	25	100	16	33	86	102	19	30
Ill.	108	191	4	147	2	-	-	20
Mich.	55	124	140	105	1	-	4	10
Wis.	31	91	-	33	-	-	-	-
W.N. CENTRAL	450	500	129	202	290	36	19	3
Minn.	75	190	66	74	202	2	19	2
Iowa	33	82	-	-	-	-	-	-
Mo.	52	107	28	46	5	9	-	-
N. Dak.	7	9	-	4	-	2	-	1
S. Dak.	127	44	7	5	1	3	-	-
Nebr.	104	27	13	21	23	3	-	-
Kans.	52	41	15	52	59	17	-	-
S. ATLANTIC	1,889	696	355	334	629	863	5	1
Del.	5	4	1	2	3	2	-	-
Md.	262	40	51	25	-	-	-	-
D.C.	19	21	4	2	29	3	1	-
Va.	352	47	36	50	-	-	-	-
W. Va.	2	4	7	10	31	28	-	1
N.C.	111	148	71	76	-	-	-	-
S.C.	24	62	23	5	106	174	4	-
Ga.	670	103	101	100	195	236	-	-
Fla.	444	267	61	64	265	420	-	-
E.S. CENTRAL	356	420	53	38	75	153	-	-
Ky.	57	135	6	16	8	18	-	-
Tenn.	22	38	47	22	67	134	-	-
Ala.	157	98	-	-	-	1	-	-
Miss.	120	149	-	-	-	-	-	-
W.S. CENTRAL	229	956	22	173	15	106	-	-
Ark.	73	216	3	-	5	12	-	-
La.	40	102	-	-	10	84	-	-
Okla.	115	13	18	26	-	10	-	-
Tex.	1	625	1	147	-	-	-	-
MOUNTAIN	193	273	335	194	25	25	-	-
Mont.	1	-	-	-	-	-	-	-
Idaho	2	14	5	3	-	-	-	-
Wyo.	3	-	6	4	9	3	-	-
Colo.	44	59	125	77	-	-	-	-
N. Mex.	46	48	55	40	16	22	-	-
Ariz.	72	115	144	67	-	-	-	-
Utah	14	16	-	3	-	-	-	-
Nev.	11	21	-	-	-	-	-	-
PACIFIC	655	714	263	148	-	1	-	-
Wash.	35	65	26	-	-	-	-	-
Oreg.	37	39	-	-	-	-	-	-
Calif.	564	593	215	126	-	-	-	-
Alaska	2	2	-	-	-	-	-	-
Hawaii	17	15	22	22	-	1	-	-
Guam	-	14	-	1	-	-	-	-
P.R.	1	6	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	6	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending May 18, 2002, and May 19, 2001 (20th Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital†					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	2,200	2,097	27	177	3,459	4,364	95	129
NEW ENGLAND	32	15	-	3	131	154	9	6
Maine	-	-	-	-	5	7	-	-
N.H.	1	-	-	-	6	8	-	1
Vt.	1	-	-	-	-	4	-	-
Mass.	19	10	-	2	77	81	8	4
R.I.	2	1	-	-	12	20	-	-
Conn.	9	4	-	1	31	34	1	1
MID. ATLANTIC	233	183	3	27	781	678	26	48
Upstate N.Y.	9	5	1	16	109	-	3	6
N.Y. City	136	109	-	-	405	393	13	10
N.J.	44	32	2	9	189	184	9	30
Pa.	44	37	-	2	78	101	1	2
E.N. CENTRAL	404	336	-	27	412	460	11	15
Ohio	54	30	-	1	60	86	4	2
Ind.	25	72	-	3	42	29	1	1
Ill.	104	118	-	21	214	244	1	7
Mich.	213	104	-	2	90	72	3	3
Wis.	8	12	-	-	6	29	2	2
W.N. CENTRAL	26	29	-	5	181	208	3	6
Minn.	10	17	-	-	82	88	2	2
Iowa	-	1	-	-	8	9	-	-
Mo.	9	6	-	3	66	43	1	4
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	7	6	-	-
Nebr.	4	-	-	-	6	15	-	-
Kans.	3	5	-	2	12	47	-	-
S. ATLANTIC	562	758	5	44	730	798	11	18
Del.	8	6	-	-	7	-	-	-
Md.	63	103	-	1	65	75	1	4
D.C.	36	14	-	1	-	28	-	-
Va.	20	48	-	1	43	84	-	4
W. Va.	-	-	-	-	9	12	-	-
N.C.	111	180	-	6	119	93	-	1
S.C.	48	106	-	9	47	75	-	-
Ga.	86	112	-	10	123	158	7	6
Fla.	190	189	5	16	317	273	3	3
E.S. CENTRAL	235	226	1	9	264	284	2	-
Ky.	37	18	-	-	48	37	2	-
Tenn.	99	133	-	4	97	97	-	-
Ala.	75	35	1	2	83	109	-	-
Miss.	24	40	-	3	36	41	-	-
W.S. CENTRAL	290	266	16	29	103	701	-	5
Ark.	11	19	-	2	49	49	-	-
La.	48	53	-	-	-	-	-	-
Okla.	27	32	-	1	54	43	-	-
Tex.	204	162	16	26	-	609	-	5
MOUNTAIN	104	77	1	7	94	181	8	4
Mont.	-	-	-	-	4	-	-	1
Idaho	2	-	-	-	-	3	-	-
Wyo.	-	-	-	-	2	1	-	-
Colo.	6	13	1	-	21	45	4	-
N. Mex.	21	8	-	-	7	26	-	-
Ariz.	69	47	-	7	46	66	-	-
Utah	5	6	-	-	12	6	3	-
Nev.	1	3	-	-	2	34	1	3
PACIFIC	314	207	1	26	763	900	25	27
Wash.	29	22	-	-	84	83	2	1
Oreg.	5	5	-	-	31	38	2	3
Calif.	276	176	1	26	575	701	21	21
Alaska	-	-	-	-	24	18	-	-
Hawaii	4	4	-	-	49	60	-	2
Guam	-	2	-	-	-	15	-	-
P.R.	78	101	-	9	8	30	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	13	U	-	U	19	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE III. Deaths in 122 U.S. cities,* week ending May 18, 2002 (20th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	399	293	76	22	6	2	36
Boston, Mass.	U	U	U	U	U	U	U
Bridgeport, Conn.	32	24	5	3	-	-	1
Cambridge, Mass.	17	14	2	1	-	-	2
Fall River, Mass.	24	17	6	1	-	-	-
Hartford, Conn.	34	26	7	1	-	-	4
Lowell, Mass.	20	17	2	1	-	-	2
Lynn, Mass.	8	6	1	1	-	-	1
New Bedford, Mass.	27	21	3	3	-	-	2
New Haven, Conn.	37	25	10	1	-	1	6
Providence, R.I.	35	21	9	-	4	1	-
Somerville, Mass.	3	3	-	-	-	-	1
Springfield, Mass.	45	32	9	4	-	-	2
Waterbury, Conn.	44	34	9	-	1	-	5
Worcester, Mass.	73	53	13	6	1	-	10
MID. ATLANTIC	2,046	1,428	402	146	39	26	117
Albany, N.Y.	60	45	10	3	1	1	5
Allentown, Pa.	15	10	1	2	-	2	2
Buffalo, N.Y.	86	62	16	4	3	1	16
Camden, N.J.	27	16	5	3	2	1	3
Elizabeth, N.J.	24	14	8	2	-	-	-
Erie, Pa.	48	42	5	-	1	-	3
Jersey City, N.J.	30	22	6	1	1	-	-
New York City, N.Y.	1,144	798	226	90	19	10	47
Newark, N.J.	71	22	28	15	1	1	8
Paterson, N.J.	19	12	5	1	1	-	3
Philadelphia, Pa.	165	106	41	10	6	2	8
Pittsburgh, Pa.§	45	40	5	-	-	-	3
Reading, Pa.	17	12	4	-	-	1	1
Rochester, N.Y.	129	95	21	7	2	4	11
Schenectady, N.Y.	15	10	2	1	2	-	1
Scranton, Pa.	18	16	1	1	-	-	1
Syracuse, N.Y.	68	56	6	4	-	2	5
Trenton, N.J.	25	17	5	2	-	1	-
Utica, N.Y.	19	15	4	-	-	-	-
Yonkers, N.Y.	21	18	3	-	-	-	-
E.N. CENTRAL	1,604	1,072	360	84	40	48	104
Akron, Ohio	U	U	U	U	U	U	U
Canton, Ohio	34	23	6	4	1	-	3
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	65	38	19	3	2	3	6
Cleveland, Ohio	118	71	35	6	3	3	5
Columbus, Ohio	231	147	67	7	2	8	19
Dayton, Ohio	126	100	19	5	2	-	4
Detroit, Mich.	177	90	59	14	4	10	7
Evansville, Ind.	49	39	8	-	-	2	8
Fort Wayne, Ind.	60	41	9	1	6	3	3
Gary, Ind.	19	9	5	1	2	2	1
Grand Rapids, Mich.	41	24	5	4	5	3	3
Indianapolis, Ind.	190	133	31	13	5	8	9
Lansing, Mich.	63	48	8	7	-	-	7
Milwaukee, Wis.	141	97	30	9	2	3	12
Peoria, Ill.	41	31	8	1	1	-	3
Rockford, Ill.	60	44	13	2	-	1	2
South Bend, Ind.	40	28	8	2	1	1	-
Toledo, Ohio	85	60	19	5	1	-	6
Youngstown, Ohio	64	49	11	-	3	1	6
W.N. CENTRAL	810	531	173	58	25	23	59
Des Moines, Iowa	224	166	38	13	3	4	26
Duluth, Minn.	30	23	3	-	1	3	4
Kansas City, Kans.	40	13	15	7	5	-	3
Kansas City, Mo.	88	54	21	7	2	4	3
Lincoln, Nebr.	26	14	8	3	-	1	3
Minneapolis, Minn.	68	42	15	4	4	3	7
Omaha, Nebr.	93	65	20	6	2	-	5
St. Louis, Mo.	81	48	21	5	-	7	-
St. Paul, Minn.	45	40	3	1	1	-	4
Wichita, Kans.	115	66	29	12	7	1	4
S. ATLANTIC	1,244	768	300	116	27	24	82
Atlanta, Ga.	159	95	38	22	3	1	6
Baltimore, Md.	182	109	44	23	4	2	27
Charlotte, N.C.	83	53	23	2	-	4	4
Jacksonville, Fla.	160	95	41	18	4	2	16
Miami, Fla.	70	46	13	4	3	4	5
Norfolk, Va.	45	28	6	1	2	-	-
Richmond, Va.	39	19	11	6	3	-	4
Savannah, Ga.	51	36	14	1	-	-	3
St. Petersburg, Fla.	63	49	9	4	-	1	3
Tampa, Fla.	192	126	44	13	4	5	11
Washington, D.C.	200	112	57	22	4	5	3
Wilmington, Del.	U	U	U	U	U	U	U
E.S. CENTRAL	830	547	176	67	22	18	62
Birmingham, Ala.	164	115	29	11	3	6	19
Chattanooga, Tenn.	62	40	16	5	1	-	1
Knoxville, Tenn.	92	56	24	9	1	2	3
Lexington, Ky.	71	52	13	3	1	2	6
Memphis, Tenn.	183	116	39	15	6	7	16
Mobile, Ala.	64	43	15	4	2	-	3
Montgomery, Ala.	31	27	3	1	-	-	4
Nashville, Tenn.	163	98	37	19	8	1	10
W.S. CENTRAL	1,528	1,000	312	134	46	34	120
Austin, Tex.	79	53	18	6	2	-	4
Baton Rouge, La.	36	27	2	3	2	2	-
Corpus Christi, Tex.	66	40	13	9	3	1	3
Dallas, Tex.	177	107	35	21	8	6	16
El Paso, Tex.	114	77	23	9	3	2	3
Ft. Worth, Tex.	143	87	35	13	6	2	17
Houston, Tex.	312	196	77	27	3	9	27
Little Rock, Ark.	75	41	20	8	3	3	4
New Orleans, La.	44	25	8	7	2	1	-
San Antonio, Tex.	260	199	35	12	8	6	26
Shreveport, La.	91	61	14	12	2	1	11
Tulsa, Okla.	131	87	32	7	4	1	9
MOUNTAIN	932	626	196	73	20	17	53
Albuquerque, N.M.	113	79	18	10	5	1	6
Boise, Idaho	33	26	6	1	-	-	2
Colo. Springs, Colo.	91	61	22	3	3	2	5
Denver, Colo.	107	66	21	11	2	7	5
Las Vegas, Nev.	259	167	57	26	4	5	16
Ogden, Utah	36	26	6	2	2	-	2
Phoenix, Ariz.	U	U	U	U	U	U	U
Pueblo, Colo.	26	19	6	1	-	-	2
Salt Lake City, Utah	93	57	24	11	1	-	8
Tucson, Ariz.	174	125	36	8	3	2	7
PACIFIC	2,206	1,567	404	148	44	43	128
Berkeley, Calif.	17	12	4	1	-	-	1
Fresno, Calif.	144	98	26	13	6	1	9
Glendale, Calif.	26	17	7	-	-	2	26
Honolulu, Hawaii	69	52	16	1	-	-	2
Long Beach, Calif.	50	33	11	2	2	2	3
Los Angeles, Calif.	923	661	171	59	17	15	-
Pasadena, Calif.	U	U	U	U	U	U	U
Portland, Oreg.	162	121	25	8	3	5	12
Sacramento, Calif.	199	147	34	12	5	1	25
San Diego, Calif.	150	104	24	14	3	5	8
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	151	101	27	16	2	5	17
Santa Cruz, Calif.	30	24	4	-	2	-	5
Seattle, Wash.	126	81	27	11	2	5	8
Spokane, Wash.	69	51	11	6	1	-	7
Tacoma, Wash.	90	65	17	5	1	2	5
TOTAL	11,599¶	7,832	2,399	848	269	235	761

U: Unavailable. -:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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